PROOF OF CLAIM

Premier Healthcare of Arizona Claim Form

ALL CLAIMANTS MUST COMPLETE THIS FORM FOR CLAIM CONSIDERATION

ALL CLAIMS MUST BE POSTMARKED BEFORE THE CLAIM FILING DEADLINE OF 5:00 P.M. MOUNTAIN STANDARD TIME ON DECEMBER 29, 2000. READ CAREFULLY BEFORE COMPLETING. REFER TO THE INSTRUCTIONS ATTACHED FOR FURTHER INFORMATION ON FILING THIS CLAIM.

FOR OFFICE USE ONLY:	
Date Postmarked:	Claimant:
Date Received:	Proof of Claim No.:

CLAIMANT INFORMATION Claimant: Please complete – Print or type	
Name:	Contract No.:
Address (Include city, state & zip):	Contract Period:
Home Telephone:	Enrollee:
Work Telephone:	Existing Claim No. (if any):
SSN, TIN or FEIN (if enrollee, medical ID):	Date Claim Incurred:

CLAIM INFORMATION

Amount of Claim:	Date Claim Became Due:

Check the statement below that best describes your claim:

_____ Claim is by **NON-CONTRACTED PROVIDER** for service provided to Premier's Subscriber(s)/Enrollee(s)

_____ Claim is by a **CONTRACTED PROVIDER** for services provided under a Provider Service Agreement

If claim is for either of the above, please also complete the "Provider Claims" section, page 2.

_____ Claim is made by an Enrollee for the benefits under the contract described above. Claim cannot be submitted for copays or deductibles. Enrollee must provide proof that payment has been made to the provider of services. Please also complete the "Provider Claims" section, page 2.

_____ Claim is made for unearned premiums due to cancellation of the contract described above.

_____ Claim is made by former employee of the Health Care Services Organization ("HCSO").

_____ Claim is made by a creditor or claimant of the Enrollee identified above.

_____ Claim is by a general creditor of the HCSO.

_____ Claim is by a secured creditor of the HCSO.

_____ Claim is other than as described above.

Describe the basis and nature of the claim and **attach all documents supporting** the claim. Attach additional pages, if necessary.

What payments have you received on this claim from Premier Healthcare of Arizona or any other source? If any, identify source and amount.

(continued on reverse side)

CLAIM INFORMATION, continued

What security or other collateral provided by Premier Healthcare of Arizona do you hold? If any, attach copies.

Do you assert any right or other specific right with respect to your claim? If yes, explain and document.

PROVIDER CLAIMS

As a provider of services or an enrollee who has been provided services by a non-contracted provider, you were furnished a Provider Claim Inventory Report ("Inventory") of claims presented to Premier Healthcare of Arizona for outstanding "pre-receivership" claims (claims for services provided before November 16, 1999). The undersigned, by Verification of this Claim Form, acknowledges that the Inventory is complete with the following exceptions (attach applicable UB or HCFA forms to support claim). Attach additional pages, if necessary. If you are resubmitting a claim that has already been adjudicated by Premier, you must provide documentation supporting your request for reconsideration. An enrollee must also submit proof if payment has been made to the provider. **Do not list or resubmit any claims already described on the provided Inventory.** ***This form must be completed and returned for any claims, including the claims listed on the Inventory, to be considered.***

Enrollee ID	Enrollee Name	Date of Service	Billed Amount	Patient Account #

VERIFICATION

The undersigned subscribes and affirms as true under penalty of perjury as follows:

I have read the foregoing Proof of Claim and know the contents thereof; that this claim of $_____ against Premier Healthcare of Arizona is justly owing to the claimant; that there is no setoff, counterclaim or defense to the claim thereto except as above stated; that the matters set forth above and in any accompanying statements are true of my own knowledge except as to matters specifically stated to be alleged upon information and belief and that as to such matters, I believe them to be true; that no payment of or on account of the aforesaid claim has been made excepts as stated above.

Date signed:_____

_____
Print or Type Name of claimant, Partner, Officer or Local Representative

Subscribed and sworn to before me this
_____ day if _____, 20_____.

_____
Signature of Individual, Partner, Officer or Legal Representative

_____
Signature of Notary Public/Commissioner of Oaths

_____
Title or Official Capacity

State of _____ County of_____

Contact Person for Claim _____

Home Phone (_____)_____

My Commission Expires:_____

Work Phone (_____)_____

[SEAL]